

A CME Course Aimed at Addressing Disruptive Physician Behavior

By Charles P. Samenow, MD, MPH, William Swiggart, MS, and Anderson Spickard, Jr, MD

Disruptive physician behavior is a form of physician impairment and has become a focus of public health attention due to its destructive impact on hospital staff, institutions, and patient care.

Five state medical societies have published data which demonstrate disruptive behaviors (independent of substance abuse and other forms of impairment) as comprising up to 30 percent of complaints received.^{1,2,3,4} The estimated prevalence of disruptive behavior in U.S. physicians is 5 percent.⁵ International data are similar.^{6,7}

Addressing disruptive behaviors quickly and early is important. Consequences of disruptive behavior include:

- Disharmony and poor morale
- Staff turnover
- Incomplete and dysfunctional communication
- Heightened financial risk and litigation
- Reduced self-esteem among staff
- Reduced public image of hospital
- Financial cost
- Unhealthy and dysfunctional work environment
- Potentially poor quality of care^{8,9,10,11}

In a recent survey, 51 percent of nurse respondents reported that they knew of nurses who left the hospital as a result of disruptive physician behavior.¹² It has been estimated that 3 to 10 percent of medical students demonstrating unprofessional behaviors have had medical errors and malpractice suits as a result of their behavior later in their careers.¹³ It is thought the rate is significantly higher for practicing physicians.¹⁰

Despite acknowledgement of disruptive behavior as a public health problem, many hospitals, practices, and

IN THIS ARTICLE...

Examine the results of a study of physicians with disruptive behavior who went through a special training program to help them better control their anger and outbursts.

licensing boards do not have effective means for handling disruptive behaviors. They may be unaware of resources available, find intervening unpleasant, or may believe that such physicians are not capable of change.^{5,14}

As a result, many of these physician's behaviors are tolerated until a crisis emerges such as a patient injury or staff complaint at which time disciplinary action ensues.¹⁴ Most of the literature addressing disruptive physicians focuses on administrative interventions and legal safeguards for institutions.^{15,16} There is little literature that describes interventions aimed at behavioral change.

However, a three-day Continuing Medical Education (CME) course titled "The Program for Distressed Physicians," followed by three day-long booster sessions over the course of six months aimed at addressing disruptive physician behavior is showing some promise.

Why a CME course?

CME courses have emerged as a unique and effective way to offer a brief and non-stigmatizing intervention to address problematic behaviors among physicians.^{17,18} The Center for Professional Health (CPH) at Vanderbilt University Medical Center was formed in late 1997 as a new educational, research and prevention resource to address matters of physician health by providing CME courses.

To date, more than 900 health professionals from throughout the United States and Canada have been referred to the CPH for CME courses regarding the prescribing of controlled drugs^{19,20} and maintaining professional boundaries.²¹

The Program for Distressed Physicians was developed in 2004 as the result of the growing recognition surrounding disruptive physician behavior as a public health program. The program was modeled after other CME courses because many disruptive physicians are high performers, do not have severe psychopathology, and may be maladaptively responding to frustrations with health care systems and/or burnout.^{22,23} It was felt that a CME course could provide an appropriate level of intervention that addresses these behaviors in a safe, effective and time-efficient manner.

Course description

The Program for Distressed Physicians is an innovative small group course that uses interactive and experiential exercises to teach specific communication and emotion regulation skills. The program uses the term “distressed” physician behavior because this term focuses on understanding the etiologies of the behavior and is less pejorative than the word “disruptive.”

A small group format was chosen based on the experience from other CME courses and because such a format provides a safe environment for physicians to share their experiences and emotions. The program (46.5 hours CME) comprises four key components:

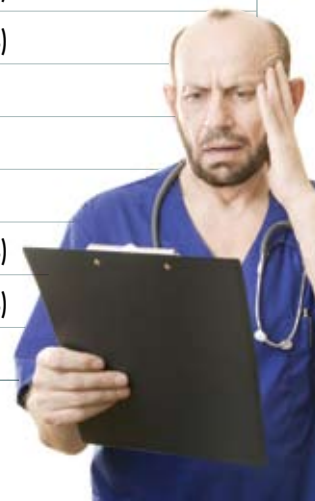
1. Referral: Referrals to the course come from state medical societies, hospitals and practices. Self-referrals, while uncommon, are also accepted. Appropriate referrals include a physician who is currently working, does not require residential treatment, and who has support for change such as a state physician health program or institutional/group practice support. Collaborative information is obtained to rule out severe psychopathology or alcohol and drug problems. If

Table 1

Characteristics of 20 Physicians Enrolled in the Program for Distressed Physicians

DEMOGRAPHICS	
Mean Age	44.6 (+/- 7.84)
Age Range	27-61
Caucasian	20 (100%)
Male	18 (90%)
Female	2 (10%)
Married	12 (60%)
Single	1 (5%)
Divorced	3 (15%)
Multiple Marriage	3 (15%)
Unknown	1 (5%)
Specialty	
Emergency Medicine	3 (5%)
Family Medicine	2 (10%)
Internal Medicine (Specialty)	6 (30%)
Ob/Gyn	3 (15%)
Pathology	1 (5%)
Pediatrics (General)	1 (5%)
Pediatrics (Specialty)	1 (5%)
Surgery (General)	2 (10%)
Surgery (Specialty)	2 (10%)

Continued on page 32



such conditions are identified during the course, referrals to more intensive treatment centers are made.

2. The CME course: The core component of the program is a three-

day experiential, on-site, faculty led group process. Each course involves a maximum of eight physicians. The course includes a) didactics and behavioral exercises that focus on communication assertiveness and identifying

Table 1

Continued from pg 31

Practice Type	
Hospital	8 (40%)
Group/Partnership	14 (70%)
Solo	2 (10%)
Resident/Trainee	1 (5%)
Prior Mental Health	
Therapy	13 (65%)
Unknown Therapy	1 (5%)
Psychotropic Medications	5 (25%)
Unknown Meds	5 (25%)

triggers that lead to emotional flooding and disruptive behaviors, b) exploration of how family of origin issues such as trauma, alcoholism, and fundamentalism influence their current behaviors at home and work^{24, 25}, c) role playing to confront the problem physician and challenge him to take accountability and develop more productive behaviors^{25,26} and d) homework assignments to reinforce concepts presented during the three-day course.²⁷ As a part of the course closure, each participant presents a three-point written “intent to change”^{28, 29} plan with specific actions and dates highlighted. These are critiqued by the faculty and peers.

- 3. Follow-up sessions:** Recognizing that behavioral change is a challenging and longitudinal process, the course includes three follow-up sessions. The goals of the follow-up sessions are to monitor behavior change, reinforce positive efforts, explore obstacles and provide accountability and cohesion through group feedback.
- 4. Workplace monitoring:** Direct feedback from workplace supervisors regarding physician behavior is solicited throughout the course.

As part of the initial assessment and follow-up, physicians complete the Physicians-Practitioners Universal Leadership Skills Survey Enhancement (PULSE)³⁰ which includes input from workplace supervisors, hospital and clinic staff and physician peers.

Participants

To date, 26 physicians have participated in the program. Six physicians did not sign waivers. For the 20 study physicians, we reviewed demographic data and collateral reports from intake, employers, psychological assessments, medical societies and licensure boards.

The characteristics of the physicians who participated in the study are shown in Table 1 with most physicians being middle-aged (44.6 years old +/- 7.84), Caucasian (100 percent) males (90 percent) married (70 percent), and previously engaged in some type of psychotherapy (65 percent) or taken psychiatric medications (25 percent) before enrolling in the course.

A wide variety of specialties were represented with the major-

ity (70 percent) of participants from group practices or partnerships. Eleven different states were represented with physicians practicing in a variety of different community sizes.

Figure 1 demonstrates the types of disruptive behaviors identified. The most common forms of disruptive behavior (90 percent) were verbal threats and use of intimidating language. Several cases of physicians who used intimidating or threatening contact (four physicians) and engaged in sexual harassment (two physicians) were also referred to the course.

Passive and passive/aggressive behaviors such as not responding to call, poor communication, inappropriate charting and refusing to engage in clinical responsibilities were also common (seven physicians combined). In reviewing the actual complaints against the physicians, there were only two cases that directly involved acting out with patients. The majority of behaviors were aimed at colleagues (100 percent), followed by staff (77 percent) and administrators (63 percent).

Table 2 illustrates the referral source for each physician with most physicians being referred from an employer (35 percent) or state medical society (35 percent). Participation in the CME course often constituted only part of the intervention for the physicians' disruptive behavior. Table 3 shows the interventions physicians experienced either prior to or concurrent with their participation in the course.

Measuring behavioral change

The primary outcome measures for the course are changes in motivational and disruptive behaviors. Motivational behaviors include a physician's ability to handle stress effectively, communicate appropriately, and include their staff and colleagues in decision-making and problem-solving in a respectful and productive manner.

Disruptive behaviors include both aggressive behaviors such as verbal and physical outbursts, as well as passive/aggressive such as negativity, derogatory comments and passive behaviors like unresponsiveness. Also of interest is the impact of motivating and disruptive behaviors on the health care team.

Behavioral change and impact was monitored using the PULSE survey. The PULSE involves three steps.

1. First, the identified disruptive physician completes a “self-rating” on the survey.
2. Second, raters from various workplace groups (referred to as “others”) are mailed the same survey (e.g., practice and/or hospital staff, physician-colleagues and supervisors/administration.)
3. Third, the surveys are scored by the Physicians Development Program (Miami, FL)³⁰, feedback comments are listed, and a feedback report is prepared. Behaviors were measured using the PULSE as part of the initial assessment and then again at follow-up (three-month and six-month).

Pre- and post-course PULSE data were analyzed using paired t-tests for the four outcome variables (disruptive behavior, disruptive impact, motivating behavior, and motivating impact) for both self and others’ (aggregate of staff, colleagues, and supervisors) reports. Differences in self-reported versus behavior reported by others were tested for each outcome variable to determine if there were significant reporting differences.

Since the sample size was small, we conducted multiple specific tests using a Bonferroni correction instead of a larger multivariate analysis. Six-month follow-up data were insufficient for statistical analysis, but descriptive data are reported. Effect sizes are reported for all statistical

Table 2

Referral Source for Physicians Enrolled in the Program for Distressed Physicians

Referral Source	# of Physicians
Employer	7 (35%)
Physician Health Program	7 (35%)
Board of Licensure	3 (15%)
Treatment Center	2 (10%)
Self	1 (5%)

Table 3

Interventions Prior/Concurrent to Participation in the Program for Distressed Physicians

OTHER INTERVENTIONS	# of Physicians
Confrontation by Practice/Hospital	19 (95%)
Required Psychological Assessment	7 (35%)
Involvement of Physician’s Health Program	7 (35%)
Formal Disciplinary Action: Probation/Suspension of Privileges/Termination	6 (30%)
Leave of Absence	3 (15%)
Action Taken by Board of Licensure	2 (10%)
*Termination of Employment	2 (10%)

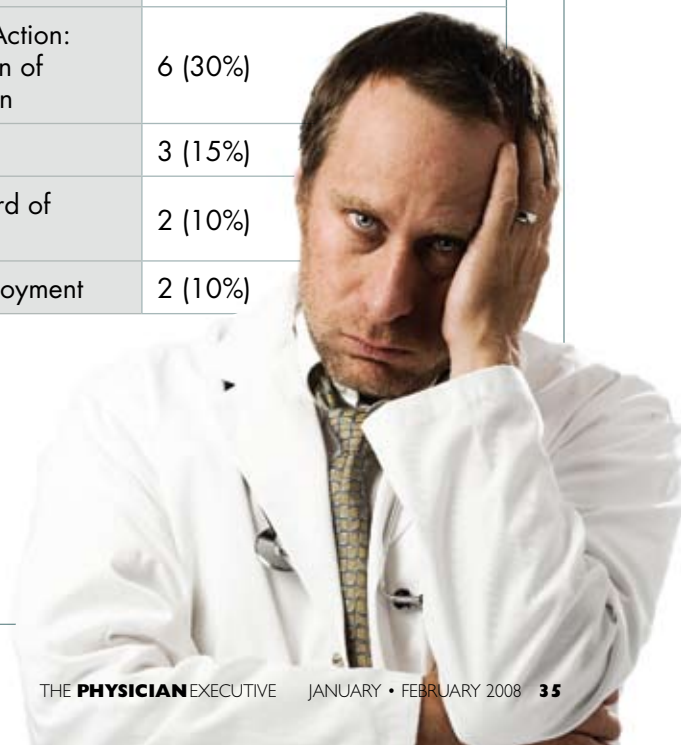


Table 4

P-Values and Effect Sizes Calculated for Physician Behavior Changes

	Mean Change in PULSE	t	Effect Size (d)	P-Value
Motivating Behaviors				
Self	.26	-1.69	.21	.12
Others	.38	-3.80	.39*	<.001
Disruptive Behaviors				
Self	-.38	1.62	.32	.14
Others	-.40	5.22	.52*	<.001
Motivating Impact				
Self	.21	-.83	.12	.42
Others	.26	-3.83	.37*	<.001

* = large effect size df(self) = 10 df(others) = 13



tests. SPSS version 14 software package was used for the analysis.

Results

Of the 20 physicians who enrolled in the course and consented to participate in this study, we received completed pre-course PULSE data on 14 physicians (75 percent), three-month follow-up data on 13 physicians (65 percent) and six-month follow-up data on five physicians (25 percent).

Failure to complete the PULSE was due to a variety of circumstances such as a physician who 1) is currently not in practice, 2) has changed jobs, 3) is in a small solo practice where the number of respondents is too small, 4) is resistant to completing it, or 5) refuses to complete due to legal advice. The average number of staff, colleagues, and administrators who provided feedback on the PULSE for each physician was 26 individuals (Range: 12 – 73).

Prior to the course, there was no significant difference seen between how physicians self-rated their behaviors compared to how others rated it prior to the course. At three-month follow-up, physicians who participated in the CME course showed a mean increase in motivating behaviors and impact and decrease in disruptive behaviors and impact.

These changes were significant ($p < .05$) for how other’s viewed physicians behavior, but not for self-report. Table 4 shows the mean changes in PULSE scores, effect sizes, and p-values for pre/post course changes in behavior in all domains.

When looked at individually, score patterns suggest improvement for 11 of the 13 physicians (85 percent) by other’s report and seven of the 13 physicians (54 percent) by self-report at three-month follow up.

Figure 2 shows an example of the individual changes for disruptive behaviors. Similar trends exist for motivating behaviors as well as

disruptive and motivating impacts, but are not shown here. Visual inspection of the six-month follow-up ratings (Figure 3) suggests maintained and/or continued improvement in all domains for three of the five physicians who have follow-up data.

Qualitative analysis

To examine the role that the course may play in behavior change, we reviewed data from course evaluations, letters to the program and observations at the follow-up sessions. These data indicate that the physicians attribute much of their change to the experience of the CME course and the skills learned through participation.

Fourteen of the 20 participants (70 percent) provided written comments at the last (six-month) follow-up session. Of those physicians, 93 percent responded that after the course they had a better understanding of how their behavior affected patient care and that the course

helped them change their attitudes and behaviors.

Further, they also were able to identify at least one specific change in their behavior both professionally and in their personal lives that they attributed to skills learned in the course.

Furthermore, in the CME course evaluations, physicians ranked activities that focused on building communication skills and identifying triggers for emotional dysregulation as the most “effective” and “helpful” components of the course (average score of 4.6 out of 5 on rating scales).

Discussion

Not only does the study yield important demographic information about our cohort of 20 disruptive physicians, but the preliminary data on the 13 physicians who completed the CME course and both pre- and post-PULSE also offer promise that disruptive behaviors can improve for at least a subset of this population. Along with qualitative feedback, it appears that the CME course may play a significant role in facilitating that change.

Similar to the survey of physician executives conducted by Weber⁵, physicians enrolled in this study demonstrated predominantly aggressive behaviors aimed at other members of the health care team. Less common were behaviors that could be classified as passive or passive/aggressive, although these behaviors may be under-reported. Direct involvement of patients in unprofessional behavior was rare.

Consistent with reports from other treatment programs³¹, our findings also support reports that disruptive physicians tend to be male, young (average age of physicians referred to other CPH courses = 49 years old) and more likely emerge from interventional disciplines.

The large number of physicians who had previous individual and/or marital psychotherapy exposure (65 percent) may also support find-

ings that disruptive physicians have long-standing family of origin and/or developmental issues that predispose them to their behaviors.^{24, 25} We have observed that most of the physicians in our course identify such issues in their family of origin exercises.

The preliminary data showing improvements in motivating behaviors and reductions in disruptive behaviors are promising. Of particular interest is that only colleagues’, peers’ and associates’ ratings show statistical significance in behavior change.

Clearly, in terms of workplace dynamics and patient care, it is encouraging that the most significant changes were observed by others, as opposed to being exclusively self-identified. This finding may also support Harmon’s unpublished find-

ings from 31 physicians using the PULSE that disruptive physicians often lack insight into their behaviors and that colleagues/staff are more sensitive to improvements in behavior change.²⁶

The results from this study are limited due to the small sample size, the short follow-up period and the fact that PULSE data are based upon physicians’ self-report and collateral sources who are chosen by the physician. Hence, the PULSE may under-report disruptive behaviors and over-report motivating behaviors.

Furthermore, the sample of participants who were compliant with behavioral monitoring may represent a less severely impaired group of physicians who are more amendable to change. A review of referral complaint types and other disciplinary interventions suggest that some of

Figure 1

Types and Frequency of Disruptive Behaviors Identified in Physicians Referred to the CME course.

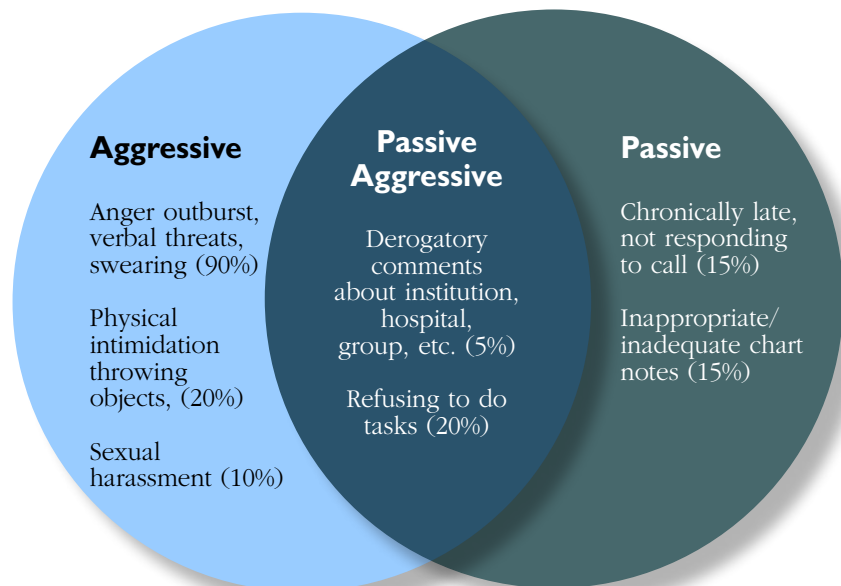


Figure 2

Others' Reports of Individual Physicians' Disruptive Behaviors Before and After the CME Course.

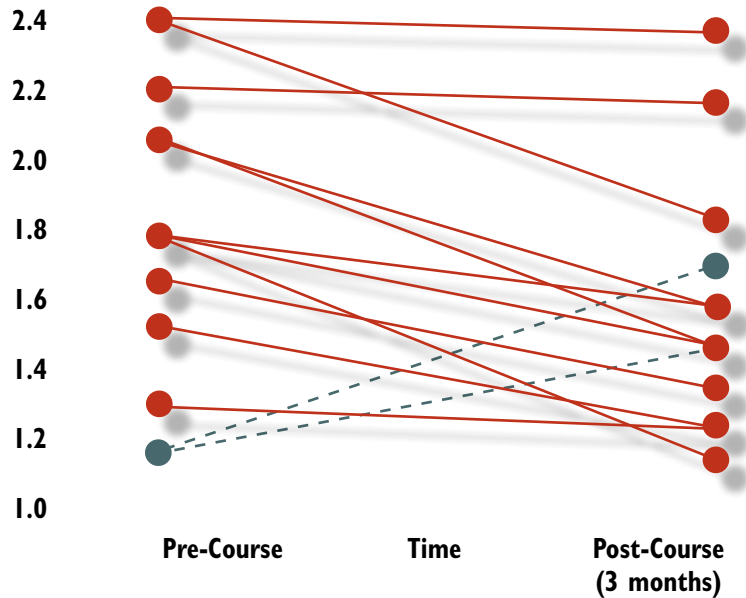
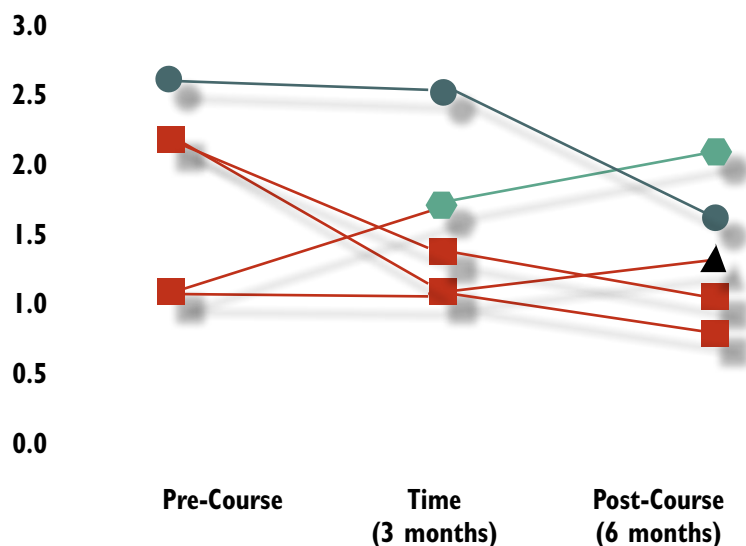


Figure 3

Others' Ratings of Disruptive Behaviors (Pre-Course, 3-month and 6-month Follow Up)



the more severely disruptive physicians (two terminated physicians, one license revocation, and one letter of concern from a Board of Medical Examiners) were among the non-completers of the PULSE.

Finally, it is difficult to determine the specific role this course had in behavioral change. The initial PULSE's are administered usually when the physician is most under scrutiny and when his disruptive behavior has become considered out of control. Alternatively, it may be that behavioral monitoring might have the greatest influence on behavior.

Studies have shown that physicians' practice patterns and behaviors can change when data show them to differ substantially from their peers, especially if the messenger and method of disclosure are appropriate, strategies for practice changes are available, and the administrative environment is supportive.¹¹ More research is needed to determine what components of the CME are most responsible for behavioral change.

We believe that The CME Program for Distressed Physicians is a unique intervention that demonstrates great potential for addressing disruptive physician behavior by contributing to positive behavior change and improved emotional health.

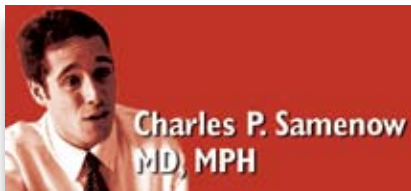
As more physicians complete the course, we expect to be able to offer a better understanding of these behaviors with a particular focus on risk and protective factors that can guide interventions. With a larger sample, we expect to be able to complete a more complex analysis of the PULSE data.

For example, we noticed that a few physicians who worked in multiple settings showed dramatically different ratings on the PULSE by colleagues depending on the type of practice setting. This supports Williams's research that certain

systems factors may play a role in enabling these behaviors.²²

We also noticed in a few reports discrepancies between how physician's nursing staffs rated their behaviors as compared to colleagues or administrators. Understanding these patterns will be important in understanding the etiology and nature of these behaviors as well as in developing future intervention.

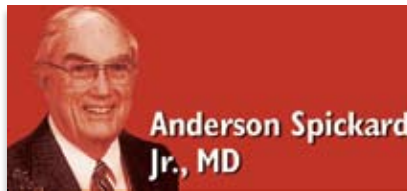
Finally, while the six-month follow-up data offer promise, future research is needed to assess physicians on a more longitudinal basis to determine whether behavioral change persists after intervention.



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